

EMPIRICAL STUDY

To be an immigrant and a patient in Sweden: A study with an individualised perspective

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Abstract

The aim is to describe how experiences of being an immigrant can influence the situation when becoming a patient in Swedish health care. A hermeneutic approach was used. Sixteen persons born in non-Nordic countries were interviewed. The data was analysed with an empirical hermeneutical method. The findings indicate that positive experiences (i.e., establishing oneself in a new home country) enhance the possibilities of taking part in caring situations and vice versa. Hence, there is a need for individually adapted care that takes one's whole life situation into consideration. Consequently, it is suggested that the concept, "cultural competence" merely serves the purpose of illuminating caregivers' need for categorisation. It does not illuminate individual needs in a caring situation.

Key words: *Ethnicity, Gadamer, hermeneutics, Ricoeur, transcultural health*

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Introduction

During the latter half of the 20th century and the beginning of the 21st, immigration to Sweden increased so much that Sweden now can be described as a multicultural society. In terms of number of immigrants and countries of origin, variations over time are considerable. From the 1970s and onwards, labour immigration was replaced by refugee immigration that reflects global war and unrest. At the beginning of the 21st century, non-natives represented approximately 12% of the total population or 1.1 million people (Ekberg, 2007).

When comparing the occurrence of bad health between ethnical Swedes and those with an immigrant background, there is obviously a higher risk of contracting bad health among immigrants. To some extent, this can be explained by the living conditions in the immigrants' native countries or their experiences of war or persecution (Vogel, 2002). In Sweden, it has also been common for labour immigrants to have physically hard jobs that might affect their health negatively (Socialstyrelsen, The National Board of Health and Welfare, 1994). An additional explanation

is the negative health effects of segregation and marginalisation in society (Groglopo, 2006).

In health care research, caring for patients with immigrant backgrounds has become an extensive research area. Earlier research can be divided into three perspectives: The first directs interest to patients according to their ethnical background and emphasises specific cultural needs. Examples of this perspective are studies of patients from Iran (Akhavan, Bildt, & Wamala, 2007; Emami, Benner, Lipson, & Ekman, 2000), Finland (see e.g., Heikkilä, 2004), Somalia (Wallin, Löfvander, & Ahlström, 2007), Thailand (Lundberg, 2000), and the former Yugoslavia (Hjelm, Bard, Nyberg, & Apelqvist, 2003). These studies highlight the norms and values derived from one's ethnical background (Hjelm et al., 2003). The second perspective strives for individualised care for all patients, irrespective of ethnical background (see e.g., Gerrish, 2000, 2001). According to Gerrish, caregivers must challenge their preconceived opinions about patients' age, sex, ethnical backgrounds, and so forth. An interesting aspect in these findings is the differences in how care provided to patients with an immigrant background *should* be and how it really is (Gerrish, 2000). For example, it has been found that

patients non-fluent in the majority language have lesser access to health care services (Elder, 2003; Gerrish, 2001) as caregivers often fail to understand the patients' needs if they do not speak the same language (Gerrish, 2001; Gerrish, Chau, Sobowale, & Birks, 2004; Thyli, Athlin, & Hedelin, 2007). The third perspective, which this study represents, is focused on patients' life situation before, during, and after their migration process and its meaning for health. In Sweden, few studies are focused on this; still integration may affect one's experience of health and well-being (Akhavan et al., 2007; Samarasinghe & Arvidsson, 2002). Even 6 years after migration, unemployment and discrimination affect health negatively (Akhavan et al., 2007). The opposite is also the case since employment increases health (Hjelm, Bard, Nyberg, & Apelqvist, 2005). Therefore, the present study directs interest to persons with an immigrant background living in Sweden. The aim is to describe how experiences of being an immigrant can influence the situation when becoming a patient in Swedish health care.

Method

The study design follows the principles for empirical, hermeneutic caring research described by Nyström in Dahlberg, Dahlberg, and Nyström (2008). Such research views individuals as living entities and is focused on the world as it is experienced by the participants of the study. The hermeneutic phase of interpretation requires an open attitude to the research situation and the research questions as well as efforts to move beyond the researchers' preunderstanding (Dahlberg et al., 2008). Therefore, the open attitude was guided by the hermeneutic philosophy of Gadamer (2004/1975).

In order to explain latent meaning in the data, the analysis was also influenced by Ricoeur's (1976) French contribution to hermeneutics, who suggests that understanding generates a correlative dialectic in reading between comprehension (the *verstehen* of the German hermeneutical tradition) and explanation (the *erklären*). The intent is to move beyond given conditions and avoid linear or causal explanations. To develop this process, Ricoeur suggests the use of theories to broaden the possibilities to explain and make room for tentative interpretations (Ricoeur, 1976).

Settings and participants

The strategic selection of participants aimed to obtain variation with regards to native country, age, sex, and contacts with the health care services. The selection was adults with residence permits in

Sweden, who were born outside the Nordic countries and immigrated in 1970–1995 at the age of 18 or older. Six participants were contacted through three health care centres and a municipal network for immigrants. Ten were contacted via so-called snowball sampling (Polit & Beck, 2006) and immigrant organisations. All participants were or had been patients in Swedish health care.

In total, 16 persons, 10 women and 6 men, aged 32–65 participated in the study. They were born outside the Nordic countries and had immigrated to Sweden in 1975–1994. All are fluent in Swedish but differed in terms of age, native country, and arrival to Sweden. Also, there were substantial differences concerning their living conditions when growing up and their educational level. They also had different illnesses that caused the contact with Swedish health care, either ongoing or discharged.

Data collection

The data were collected through open interviews by the first author (EBB) that took place in the participants' homes, workplaces, or in a library. The participants were encouraged to talk openly about their experiences. Two opening questions were posed to each participant: "Please tell me what it was like when you came to Sweden" and "Could you please tell me what it is like being a patient in Sweden?" These initial questions aimed at inviting the participants to recall and reflect on their experiences. In order to focus on the participants' experiences, the initial questions were supplemented with questions such as, "Could you please tell me more about this?" or "What did this mean to you?" This made it possible to successively adapt the interview situation to each participant's lived experiences. All interviews lasted 45–90 min, were tape-recorded, and transcribed verbatim by the first author.

Six informants, three women and three men, were interviewed twice. According to the principles suggested by Ödman (2007), those selected for follow-up interviews had made the deepest and most varied contribution to the data. The follow-ups were conducted 3–15 months after, were shorter and more precise (only 30–60 min). The focus was possible after a preliminary interpretation of the first interview, so as the interview questions were formulated according to this understanding of each participant's initial story.

Data analysis

The first interviews resulted in a substantial mass of material with considerable variation. In order to

keep to the individual perspective and avoid depicting immigrants as a homogeneous group, every interview was analysed separately. When an overall insight of the content was obtained, attention was directed towards its diverse meanings related to the aim of the study. The interpretative phase began. Ideas for interpretations were sought and identified in all interviews, were written down, and their validity was examined according to the following criteria introduced by Trankell (1972) and Ödman (1992):

- The source of a valid tentative interpretation should only be an actual piece of data. An interpretation that leaves a considerable amount of the same data unexplained is viewed as weak.
- For a valid tentative interpretation, there should be no other interpretations that to the same degree or more meaningfully explain the same data.
- There must be no contradictions in the data behind a tentative interpretation that is considered valid.

After the follow-ups, some interpretations were developed further. Others were rejected since they did not fulfil the validity criteria. The individualised interpretations from the participants who were interviewed twice were concluded with an existential interpretation for each participant's story. According to Ödman (2007), an existential interpretation suggests how a person understands his or her situation in the world; thus, it is directed towards meaning. In this study, the existential interpretations aimed at explaining how the participants experienced their life situation and how it influenced their experiences of being patients in Swedish health care.

Next, a comparative analysis of all individual existential interpretations searched through them for similarities and differences in order to interpret any patterns of meaning. Here, the interpretations were developed by the use of Sartre's (1992) existential philosophy. This resulted in a comprehensive understanding that illuminated the importance of taking past, present, future plans, and dreams into consideration when trying to understand a person's lifeworld.

In order to uphold an open attitude during the research process, the researchers strived to define and disregard their preunderstanding as much as possible. During the data collection, this was obtained through open-ended questions and follow-up questions directed to the participant's story. The same attitude was used during the data analysis; the transcribed interviews were read and questions

were asked to the data, which made it possible to reflect and disregard the researchers' preunderstanding. When choosing Sartre's existential philosophy for developing the comparative analysis, the open attitude was partly dropped. However, using theories as analytic tools in a hermeneutic study are consistent with an open attitude we argue. Of course, a team of researchers have limited knowledge of all existing theories; and theories might decrease the influence of the researchers' preunderstanding, as suggested by Ricoeur (1976).

Ethical considerations

The study was approved by the Ethic Committee of Sahlgrenska Academi, Göteborg University (D-nr 573-03). Before the interview, the participants were informed about their voluntary participation and their right to withdraw at any time without stating any reason for doing so. Written informed consent was obtained from all participants. In order to protect the identity of the participants in the findings sections, summaries of data are used instead of quotations. The name of the participants and some of the circumstances in their stories have been changed, so only their approximate ages, and so on are reported.

Results

Due to the article format, the findings only present a brief summary of the data from the six participants who were interviewed twice followed by a shortened version of each existential interpretation to illuminate different aspects of the participants' experiences. Finally, a comparative analysis and comprehensive understanding is presented that includes all data from all 16 participants.

Annie is a Middle East divorced mother of two in her 40s who came to Sweden in the beginning of the 1990s. After 2 years of unemployment, she found an industrial job that caused her intervertebral disk displacement after only a couple of months. The pain was eased with rest, pharmaceuticals, and physiotherapy. Annie appreciated the Swedish health care, but one reason was probably that the injury showed on X-ray, she says. But contacts with the social insurance office did not work out very well. After 1 year on the sick list, Annie was no longer entitled to sickness allowance and was told she had to leave or go back to work. At that point, she thinks her immigrant background was a disadvantage and therefore she was determined to get back to work.

Existential interpretation. Annie knew what it was like to be unemployed when she was put on the sick list. When no longer qualified for sickness allowance,

Annie was confronted with her double vulnerability; that is, her immigrant background and the fact that she could not perform physically heavy tasks. Due to her previous experiences of unemployment, she felt she had only one option left: return to work. But as a patient, Annie thought she received good support from the caregivers. In spite of her difficulties, Annie seems to be a woman who makes important decisions for herself. Even though she did not consider herself with entirely positive options, she did the best in her problematic job situation. Today, she works full-time even though some tasks still cause her pain. Probably, it strengthens her self-esteem to solve difficult situations despite setbacks.

Daniel is a married, father of three in his 60s who works as a physiotherapist. In the late 1970s he came to Sweden from Latin America as a refugee. He believes that Swedish health care is great for patients with concrete, physical problems. One time undergoing appendectomy surgery, without informing him, a tissue sample was taken and it turned out positive for colon cancer. This information was sent to him via e-mail. Daniel regarded this way of informing him about such serious matters disrespectful. However, new surgery was necessary and at this occasion all caring interventions were satisfying, which Daniel suspects was because as a physiotherapist, he could pose adequate questions. This, he pointed out, was unfair to patients who lack such competence, for example those non-fluent in Swedish. During the second interview, Daniel also talked about his participation in a group for cancer patients, which made it possible for him to share his experiences of being a cancer patient. Understanding that he was not alone made it easier for him to deal emotionally with cancer.

Existential interpretation. Besides the fact that a cancer notification was sent to him via e-mail, which must be regarded as a mistake on the part of the health care services, Daniel's reaction was also an existential exposure of being afflicted with cancer. Nevertheless, Daniel was satisfied with the treatment he received. One reason for his quick adaptation to the role of a "competent patient" was probably his knowledge from being a physiotherapist. Therefore, the existential interpretation aims at understanding more of the criticism he brings up. He did succeed in reaching the caregivers' ears by talking like a professional. For example, he asked questions about the test results and different treatments. As a consequence, Daniel toned down his existential needs until he could reflect on his experiences of being a cancer patient to the group. Daniel's story illuminates how one's vulnerability increases when you find yourself in a situation that it is impossible to get out of. Daniel found a solution by considering his

options and put away the existential world (i.e., his lifeworld) for a while in order to be a competent patient.

Eric is a married, father of two in his 40s who came from the Middle East 15 years ago and works as a native language teacher. In his former home country, Eric belonged to an ethnic minority group and was often met with suspiciousness. In Sweden, he wanted to earn a living and become an "average Joe." For a while he worked as a cleaner but had a backache and was put on the sick list. But the ache did not go away, so Eric went to a new physician. Then his social secretary asked questions about his change of doctors. Eric's feelings of being called in question reminded him of his feelings of belonging to an ethnic minority in his old home country. Another example was when Eric was bothered by eczema. He sought help at a health centre but felt neglected. In the second interview, he reflected on the similarities of being questioned in his old country and the social security office in Sweden. He believed that his reaction was related to his background. Nevertheless, Eric chose another health centre and, here, he was satisfied with their attitude. Eric did feel discriminated in Sweden, but not much to compare to the oppression he fled from, he said. He described it more as a feeling of not being seen as a Swede. Such feelings made him give up his efforts of becoming an average Joe and nowadays he mostly socialises with fellow countrymen. Also, he pointed out that if people with immigrant backgrounds are discriminated in the health care sector it is not as obvious as on the labour market.

Existential interpretation. Eric said that he often feels questioned. According to his own interpretation, this might be caused by the situation when he belonged to an ethnic minority in his former homeland. During his first years in Sweden, he built up his self-esteem by trying to be accepted as an average Joe. However, this ambition had to yield to his need of fellowship so he turned to his fellow countrymen. Thus, it seems as if Eric adapted to the shortcomings of the Swedish society's integrating immigrants. This could also explain why he felt questioned when he became a patient and had contacts with the social security office.

Helen is in her 50s who came from Eastern Europe with her husband and son 15 years ago because her husband was a political dissident. In Sweden, Helen went to the university and became a doctoral student. But she quit her doctoral studies and found it hard to find a job that matched her competence. Feeling rejected with general feelings of illness, Helen was either on the sick list or unemployed for years. At the time of the first interview, Helen was on the dole while working at a meeting place for

immigrant women. By the second interview, Helen was unemployed again because she was considered ready for “ordinary work.” She claims that her immigrant background is a problem on the labour market but not in contacts with the health care, where it does not seem a disadvantage having an immigrant background. But in society immigrants’ knowledge and education have very low value, Helen believes, and unemployment has affected her negatively. She used to be a happy and positive person but has lost her faith in the future.

Existential interpretation. After a successful initial period in Sweden, Helen entered a vicious circle of failures that led to identity changes. There are substantial differences between the life she leads and the life she wants to live. This is obvious when she compares her hopes and dreams during the first years in Sweden with her current state that is characterised by poor health. During both interviews, Helen was pleased with her health care contacts, but those with the labour market were worse, where she believed that her immigrant background was a disadvantage. Here it is tempting to enter a new identity (e.g., that of a patient). If so, the worst threat is that the unemployment benefit scheme tells her to find an ordinary job. Paradoxically, if Helen is allowed to continue as a patient, it would seem to work out for her.

John is in his 60s and married with two grown-up children born in Sweden. John and his wife fled from a military dictatorship in Latin America at the end of the 1970s due to John’s political activities. In Sweden, John made an effort in trying to be open-minded for new experiences. For example, he learned Swedish even though he planned to return to his old home country. But, the longer John stayed in Sweden the harder it became to go back because of his children growing up here. Today, Sweden is the country where John feels at home. Recently John went through a successful bubonocoele surgery during which the staff talked to him and each other in a calm and objective way. He felt safe and well cared for. By the second interview, John emphasised how calm and safe he felt as a patient. An important reason for this was the caregivers’ attitude and supervision that he highly appreciated.

Existential interpretation. During both interviews, it was obvious that John’s longing for a home played a central part in his integration into Sweden. Establishing himself in Sweden, learning the language and making a living seem to have changed John both in an external and in an internal way. With the guidance of the internal world (i.e., the lifeworld), John interprets and communicates with the surrounding world. When experiencing something new, the internal world is used as a frame for how

to relate to the new experience. John appears to have positive experiences of Sweden shortly after arriving to his new home country as well as for Swedish health care. As a patient, he brings forth a picture of caregivers as people who make sure that patients understand what they say and ask questions. When he was about to be operated on, his former experiences in his internal reference system made him think that the fact that he understood what was going on during the recent surgery was something good.

Mary is in her 50s and came to Sweden from the Middle East 20 years ago. A single mother of a now grown-up son, the two fled their home country after a change of regimes. During the first interview, Mary was mostly worried about her financial situation in case of bad health. She was in touch with the health centre for check-ups. By the second interview, Mary told us about a conflict she had had with the job centre when she found a job after a fairly long time on the sick list due to worn out joints, stress, and pain. After several years on sick leave, Mary felt worthless but found a job as an English teacher for an immigrant association with financial support from the job centre. She loves her job and the students and co-workers are fellow countrymen. But the job centre believes it is time for Mary to get a permanent position, but Mary still feels stressed and she is still in pain.

Existential interpretation. The first interview was about Mary’s fear of loss, mainly in material terms. By the second interview, this rather seemed to be about loneliness. Getting sick does not mean only a financial strain but a loss of fellowship. Thus, both interviews appear to be about fear of additional losses, which seems reasonable when looking at Mary’s background. The worn out joints and the stress that put her on the sick list coincide with other losses, such as losing her original home and family. Sick leave decreased her stress, but it did not seem a relief. In the conflict with the job centre, Mary stresses her needs as a patient to avoid suffering an additional loss, which seems fair to interpret as if she emphasises her helplessness in order to protect herself.

Comparative analysis and comprehensive understanding

The comparative analysis of the interviewees’ different lived experiences was initially guided by the two concepts facticity and project. According to Sartre (1992), all people are tied to their facticity (i.e., their own history and living conditions). But at the same time, they *are* their future and their possibilities. A consequence of this ambiguity between the prerequisites and the future opportunities is that we all

live in a dualistic relation to facticity and project. For example, the facticity for some of the participants in the present study consisted of being persecuted due to political activities. This resulted in a project: to search for safe living conditions in a new home country.

However, the participants seem to hover between facticity and project. This is dialectical; a completed project means a new facticity, which constitutes the ground for new projects. In order to search for different aspects in the participants' new facticities, interpretations are needed that includes meeting with the Swedish society.

All participants described different meanings of their earlier experiences as immigrants in Sweden and their search for medical care. Their stories also illuminated parts of their processes integrating into Swedish society. They might have arrived in Sweden at different times, but in common for their migration processes was a hard facticity in their former home countries, which was the starting point for their migration projects. The participants were brave enough for leaving the well known for a new and foreign country. Irrespective of their reasons to leave, the participants succeeded migrating. When granted asylum, they found themselves in a new facticity that meant security but limited their freedom (i.e., language obstacles). For some of them, living in Sweden did not turn out as safe as they had wished. Most of them experienced vulnerability and alienation in Swedish society, especially on the labour market.

The project "establishing in Sweden" turned out differently for the participants. How successfully they dealt with their new facticities, including difficulties, had consequences on their future projects. For those having trouble with their employment status, for example, the project gradually changed into maintaining a facticity that could result in a safe situation.

The participants in this study were patients in different periods of their lives and for different reasons. Eric had lived in Sweden for a few years before he needed medical help, whereas Annie, Helen, Mary, John, and Daniel had lived in Sweden for several years before they became patients. When their experiences with the health care services are compared to that of the labour market, there is a tentative difference that those established on the labour market could return to their workplaces after the sick period. Helen and Mary did not, and they appear to lack the feeling of coherence that is important for feeling at home in a new country. Under the given circumstances, it seems fair to interpret their patient roles as homelike. Being a patient among others could thus be an unconscious

way of solving a persistent situation. For example, you could become "somebody," which is not as exposed as being unemployed. Being a person with rights to professional caregivers' attention and care could decrease feelings of insecurity.

Hence, the existential situation as a patient could be interpreted as an aspect of the participants' whole life situations. Therefore, invincible difficulties might reinforce each other, which might imply that the ambition to establish oneself in a new country is passive. Positive experiences from sorting out a difficult situation, such as migrating and then settling down in a new land could probably lead to favourable conditions for facing new difficulties, such as illness. This seems valid for active people who make their existence in Sweden satisfactory. For patients with immigrant backgrounds, it seems as if previous experiences of vulnerable situations influence how their patient situation is perceived and handled. Hence, those with positive experiences of establishing in Sweden have good possibilities of becoming part of the care when in a patient situation. Thus, the study illuminates difficulties connected to migration and incorporating new traditions and what this could mean for one's role as a patient.

Discussion on findings

This study highlights the role of patients with immigrant backgrounds in the view of their whole life situation. For example, difficulties on the labour market might have considerable consequences regarding the amount of activity and participation in the caring process. For some people, being a patient might serve as a platform in an unstable life. Thus, this study adds knowledge to the need for individual adapted care that takes the patient's life situation into consideration without prejudices about "specific cultural needs." This is stressed in an American theory that corresponds to the research field; namely, Leininger's "transcultural nursing" model that aims at formulating culturally adapted, safe, and meaningful care, as she believes that professional caregivers ought to be familiar with at least two to three cultures (see e.g., Leininger & McFarland, 2006). The model has been criticised by Gustafson (2005) among others, who claims that Leininger's model implies that the Western population is superior, so as homogeneity is imposed on the groups that are being studied. In such research, one's cultural background is used as the most important factor for explaining differences in health and well-being, and little or no attention is paid to other factor such as age, sex, educational level, or discrimination (Gustafson, 2005).

According to the findings of this study, there is a strong relation between a successful migration process and being active in one's own health care. This means that if a patient has an immigrant background, his or her individual story needs to be made visible in a caring situation. Compared to the extensive amount of research in the field (see e.g., Campinha-Bacote, 2009; Maier-Lorentz, 2008; Mancuso, 2009), these findings do not extract specific needs from the patients' origin but those from their lived experiences. This might seem like common sense, but it deviates from previous research that concludes that professional caregivers need "cultural competence" (i.e., knowledge about specific cultural habits), which does not contribute to knowledge about patients with immigrant backgrounds.

As a result, we suggest that concepts such as "cultural competence" might say more of the carers' need for categorisation in order to understand the unfamiliar than the patients' actual needs. Basing a meeting with an immigrant patient on personal interest in cultural expressions appears too one-sided. There is also a risk that caregivers treat patients based on stereotypical images of how a person from another country is supposed to act, need, or think about care, so as the emphasis on cultural diversity might lead to exaggerated differences. Besides, Öhlander (2004) claims that patients with immigrant backgrounds risk being described as problematic patients.

Hence, the findings state that individually adapted care means highlighting the patient's perspective from their own point of view. This supports a previous study from Gerrish (2000) and requires that caregivers do not have preconceptions about patients based on age, sex, or ethnicity. However, individually adapted care has its pitfalls, as has been criticised by Samarasinghe, Fridlund, and Arvidsson (2006), Thylin et al. (2007), and Cortis (2004); the latter among other claims that it is common for caregivers to arrange care on their own beliefs of what is best for the patient. In other words, the caregivers set the standard for the offered care (Cortis, 2004). For example, diabetes care in Sweden might be unequal for patients with immigrant backgrounds (Gåfväls & Wändell, 2007).

Thus, a self-critical stance for professional caregivers appears motivated. An open attitude towards patients might seem easy to achieve but, in fact, it demands reflections about one's own preunderstanding. Gadamer claims that preunderstanding is essential for mankind, so it is both a necessity and an obstacle to the search for "otherness" in data. Thus, Gadamer invites us to self-criticism (Gadamer, 2004/1975), which makes it important for caregivers

to have lifeworld-based tutoring in caring science. Individual tutoring or in groups might increase one's ability to reflect on your preconceived opinions and prejudices (Ekebergh, 2007). Such philosophically grounded tutoring emphasises the importance that the caregiver understands the caring situation as is experienced by the patient.

Discussion on method

This hermeneutical study is based on lifeworld interviews, which were analysed by explicit interpretations with suggestions on how to explain the meanings of the data. The criteria for estimating the validity of the suggested interpretations was introduced by Trankell (1972) and Ödman (1992). However, the suggested interpretations should not be taken as a truth claim. Instead, they should be read as related to the material that forms the foundation (i.e., the data).

In order to reach a comprehensive understanding that makes it possible to understand latent meaning in the data, several interpretative ideas were initially formulated at the individual level. When more data was collected and tested according to the validity criteria, the interpretations were compared and finally a comprehensive understanding was formulated. This was first tested against the six interviews presented in the findings. Thereafter, they were tested against the whole data set that was not presented in the findings; that is, the 10 transcribed interviews that were not followed by a second interview. Moreover, the analysis process and data pieces are presented in a transparent way to enable the readers to assess the validity of the interpretation process as well as the findings.

In all studies, the researchers' preunderstanding is an Achilles' heel as every researcher, qualitative or quantitative, has a lifeworld that forms the research questions or deciding which theories to use. Hermeneutic philosophy takes into account the problems and effects of preunderstanding; Gadamer speaks of questioning it and Ricoeur requests the researcher to be suspicious of what one's preunderstandings might hide. As a consequence, the authors of this study have continuously discussed the analysis process. In order to further question our preunderstanding, our analysis and findings were reviewed by practitioners and researchers not involved in the research process.

In general, qualitative studies can be transferred within a context; in this study, immigrant persons with experiences in becoming patients in Sweden. However, the fact that the findings are contextual does not mean that they are inapplicable to other contexts. Hopefully, this hermeneutical study contributes to the understanding of similar phenomena

in other contexts as well. The field of application is limited since there were no labour immigrants or newly arrived refugees in the study. Patients under the age of 18 and those in forensic psychiatry were also excluded.

Conclusions and clinical implications

Integrating in a new society seems to be of vital importance for one's willingness to participate in care and take an active part in the relation with caregivers. Hence, this study does not confirm to the general idea that good care for patients with immigrant backgrounds is based on the caregiver's learning cultural differences, as Leininger among others have asserted. Instead, each individual's story needs to be made visible in caring situations with immigrant patients. Hence, we suggest that the concept "cultural competence" should be changed in favour of competence in understanding the life-world perspective.

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Conflict of interest

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